PA16-2006: Chronic Idiopathic Constipation

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM
FAX OR MAIL TO:
RI PA CALL CENTER
145 Technology Lane ▪ Henderson, NC 27537
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ SEX: M / F MEDICAID ID NUMBER:_____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER ( ) _____- _____

REQUESTER NAME: _____ RN /MD /R.PH / _____

PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____

DRUG REQUESTED : _____QTY / FILL _____

Specific Criteria is available at *http://www.dhs.state.ri.us/dhs/heacre/provsvcs/mpharpa.htm* OR BY CALLING 1-866-420-3874

DOES THE PATIENT HAVE AT LEAST TWO CONSTIPATION ICD-9'S SUBMITTED FROM 3 MONTHS TO 2 YEARS AGO IN ADDITION TO AT LEAST ONE ICD-9 SUBMITTED IN THE LAS T 3 MONTHS? YES / NO

DOES THE PATIENT HAVE AT LEAST 1 CLAIM FOR A PRESCRIPTION LAXATIVE IN THE LAST 6 MONTHS? YES / NO

HAS THE PATIENT TRIED AND FAILED AT LEAST 2 DIFFERENT LAXATIVES (STIMULANTS OR FIBER LAXATIVES)? YES / NO

COMMENTS:

PRESCRIBER SIGNATURE _____**DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

RI PRIOR AUTHORIZATION CALL CENTER FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)
RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874

RI PRIOR AUTHORIZATION - CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)

PA # _____ APPROVED_____ DENIED _____ PENDING ADDITIONAL INFORMATION_____
DATE /TIME OF RECEIPT _____ DATE/TIME RESPONSE _____ REVIEWER _____

COMMENTS:

Revised 7.31.2009